Authorization for Release of Health Information

State Employee Injury Compensation Trust Fund/SEICTF

Please complete, print, and sign. Fax to SEICTF at 334-223-6170 or 888-827-6753.

Patient Name: _____

Social Security #: _____

Date of Birth: _____

Address: _____

_____

_____

Phone: Work Number: _____

Home Number: _____

Cell Number: _____

I hereby authorize any physician, health care professional, hospital, or other medical care facility to provide my complete health care records to representatives of the State Employee Injury Compensation Trust Fund (SEICTF), and/or its' agents regarding my health and any treatment rendered. I authorize representatives of SEICTF and/or its' agents to examine any and all records including but not limited to: all history and physical examinations; progress notes; physicians' notes; lab reports; x-ray, MRI, CT scans, myelograms and all other diagnostic procedure reports; all consultation reports and records, in-patient and out-patient facility records; operative reports; payment records, prescribed medications; and all notes, correspondence and records of any kind.

In addition, I authorize the release of information relating to (1) communicable diseases such as hepatitis and the human immunodeficiency virus (HIV); (2) substance abuse treatment records; and (3) all mental health treatment records.

The purpose for disclosure of these records is to allow SEICTF to evaluate the patient's medical history and injuries in this claim and to administer benefits the patient may be eligible for under the SEICTF program. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original. This Authorization for Release of Health Information is valid for one year from the date the patient signed this release.

_____ _____

Signature of patient or patient's personal representative Date

_____

Relationship to patient, if signed by personal representative